

# IRI DIVISION-OF HEALTH - STANDARD CERTIFICATE OF DEATH

# =60-020233

## LED VS MAY 16 1960

 Registration District No. 251 Primary Registration District No. 3048 Registrar's No. 114

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Nodaway</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maryville</u>		Length of stay in 1b <u>2 days</u>		c. CITY OR TOWN <u>Maryville</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>420 South Charles</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EUGENE</u> Middle <u>EDWIN</u> Last <u>CRAWFORD</u>				4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>60</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7/26/76</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own account</u>		11. BIRTHPLACE (City and state or country) <u>Andrew Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Robert Harrison Crawford</u>			13b. MOTHER'S MAIDEN NAME <u>Lucy Stark</u>		14. NAME OF HUSBAND OR WIFE <u>Cora May Lyle Crawford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>495-26-3118A</u>		17. INFORMANT Address <u>Mrs. Cora Crawford, Maryville, Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>to pulmonary emphysema</u> DUE TO (c) <u>and marked pulmonary fibrosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from <u>1950</u> to <u>5/9/60</u> and last saw him <sup>be X</sup> alive on <u>5/9/60</u> Death occurred at <u>10:45</u> P. M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>E. Jones D.</u> (Degree or title)				22b. ADDRESS <u>Maryville, Missouri</u>		22c. DATE SIGNED <u>5/11/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>5/11/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Miriam</u>		23d. LOCATION (City, town, or county) (State) <u>Maryville, Missouri</u>			
24. FUNERAL DIRECTOR <u>Price Funeral Home, Maryville, Mo.</u>			ADDRESS	25. DATE RECD. BY LOCAL REG. <u>5-11-60</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Holt</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John W. Price

Licensed Embalmer No. 4281

P. O. Address Marysville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.